Bureau of Health Care Quality and Compliance

-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BUILDING		С			
		NVS3456HWH				03/0	2/2011		
NAME OF PF	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE				
WE CARE	FOUNDATION		2216 S 6TH LAS VEGAS	H ST AS, NV 89104					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
WW000	INITIAL COMMENTS			WW000					
WW004 SS=C	The findings and con by the Health Division prohibiting any crimin claims for relief that runder applicable feder. This Statement of Dear result of a State Lic your facility on 3/2/11. The survey was condadministrative Code for Recovering Alcoh Regulations, adopted of Health on Decemb date of 01/01/02.	lucted using Nevada (NAC) 449, Halfway Ho ol and Drug Abusers I by the Nevada State B er 17, 2001 with an effect d for eight beds. The covey was three. ucies were identified: UALIFICATIONS	ation I as er party ed as ed at uses Soard ective	WW004					

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

		(X1) PROVIDER/SUPPLIER/O	ER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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WW004	Continued From page 1			WW004				
	This Regulation is not met as evidenced by: Based on interview on 3/2/11, the facility failed to keep a complete personnel file for the administrator of the facility (the facility failed to have an administrator).							
	Severity: 1 Scope:	3						
WW005 SS=F	ADMINISTRATOR QUALIFICATIONS			WW005				
	NAC 449.15491 An administrator mus (2) Have the tests and required by NAC 441, employed in a facility	d obtain the certificatior A.375 for a person	าร					
	Based on interview of the facility failed obtatoby NAC 441A.375 for facility failed to have	ot met as evidenced by: n 3/2/11, it was determi in the certifications requ the administrator (the a current administrator)	ned uired					
	Severity: 2 Scope:	3						
WW006 SS=C	ADMINISTRATOR Q	UALIFICATIONS		WW006				
	NAC 449.15491: An administrator mus (3) Maintain evidence							

		(X1) PROVIDER/SUPPLIER/C		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING	<u> </u>	С	
		NVS3456HWH				03/02/2011	_
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
WE CARE	FOUNDATION			2216 S 6TH ST LAS VEGAS, NV 89104			
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WW006	Continued From page 2			WW006			
	requirements of this section in a file that is maintained on the premises of the facility. This Regulation is not met as evidenced by: Based on interview on 3/2/11, the facility failed to keep a complete personnel file for the administrator at the facility (the facility failed to have a current administrator). Severity: 1 Scope: 3						
			led to				
WW010 SS=C	ADMINISTRATOR G	ENERAL DUTIES		WW010			
	NAC 449.154911: An administrator shall: (4) Ensure that the records of the facility are maintained in accordance with the requirements of the policies, procedures and rules for the operation of the facility established pursuant to subsection 3.						
	Based on interview or ensure records were with the requirements and rules for the oper	ot met as evidenced by: n 3/2/11, the facility faile maintained in accordan s of the policies, proced ration of the facility (the evidence of any employ	ed to nce ures				
	Severity: 1 Scope:	3					
WW014 SS=C	ADMINISTRATOR G	ENERAL DUTIES		WW014			

AND DIAN OF CODDECTION		(X1) PROVIDER/SUPPLIER/O			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		_		A. BUILDING B. WING					
		NVS3456HWH				03/0	2/2011		
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE				
WE CARE	FOUNDATION		2216 S 6TH LAS VEGAS	GAS, NV 89104					
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WW014	Continued From page 3			WW014					
	and procedures estab	ve changes in the police							
	This Regulation is not met as evidenced by: Based on interview on 3/2/11, the administrator failed to annually review policies and procedures for the operation of the facility. Findings include: On 3/2/11, the policy and procedure manual was requested for review. The policy and procedure manual staff provided was last revised in January of 2008.								
	Severity: 1 Scope:	3							
WW033 SS=F	HEALTH AND SANIT	TATION		WW033					
	facility must be kept fi (b) Hazards, inclu	cticable, the premises of ree from: Iding obstacles that imp I clients within and outs	pede						
	Based on observation	ot met as evidenced by: n on 3/2/11, the facility on the outside of the fa	was						
	Findings include:								
	On 3/2/11, the south	exterior of the facility ha	ad						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING B. WING			;	
		NVS3456HWH		D. WING		03/0	2/2011	
NAME OF PR	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE			
WE CARE	FOUNDATION		2216 S 6TH LAS VEGAS	6TH ST EGAS, NV 89104				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
WW033	Continued From page 4			WW033				
	numerous old tools, mops and buckets impeding a fire egress route.							
	Severity: 2 Scope:	3						
WW053 SS=F	FIRST AID			WW053				
	The first aid kit must i	be available at the faci nclude, without limitation fe for use by humans.						
	This Regulation is not met as evidenced by: Based on interview on 3/2/11, the facility failed to maintain a complete first aid kit.							
	Findings include:							
	have a first aid kit with (a) A germicide safe f (b) Sterile gauze pads (c) Adhesive bandage adhesive tape; (d) Disposable gloves (e) A shield or mask t administering cardiop (f) A thermometer or of used to determine the person.	for use by humans; s; es, rolls of gauze and	o is ; and e					
	examine the contents	o kit was requested to the first aid kit failed the first aid kit failed the shield or mask for CP						
	Severity: 2 Scope:	3						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		NVS3456HWH		A. BUILDING B. WING		C 03/02/2011		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	1 00/0/	2/2011	
WE CARE	FOUNDATION		2216 S 6TH LAS VEGAS					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
WW060	Continued From page	e 5		WW060				
WW060 SS=F	MEDICATION			WW060				
	NAC 449.154935: (1) Except as otherwise provided in NAC 449.154933, an administrator or another client shall not administer or assist in the administration of medication to a client.							
	This Regulation is not met as evidenced by: Based on interview on 3/2/11, the facility failed to ensure the facility did not assist in the administration of medication to a client (staff reported they poured the medication from the bottle into a cap or container and handed the container to the client).							
	Severity: 2 Scope:	3						
WW079 SS=F	CLIENT FILES; MAIN CONFIDEN	NTENANCE; CONTENT	ΓS;	WW079				
	maintains a separate	shall ensure that the fac file for each client of th e file for at least 5 years y leaves the facility.	e					
	The file must be kept locked in a location that is protected against unauthorized use. Each file must contain the information obtained by the facility that is related to the client, including, without limitation:							
	(d) Evidence of co	ompliance with the 1A.380.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
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NAME OF PR	OVIDER OR SUPPLIER		2216 S 6TH		(IE, ZIF CODE				
WE CARE	FOUNDATION			GAS, NV 89104					
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WW079	Continued From page 6			WW079					
WW091 SS=C	This Regulation is not met as evidenced by: Based on record review on 3/2/11, the facility failed to ensure 3 of 3 residents complied with NAC 449.380 regarding tuberculosis (TB) testing (Resident #1, #2 and #3 failed to have evidence of a two-step TB test in the file). Severity: 2 Scope: 3 SAFETY FROM FIRE		WW091						
	ensure installed smoke detectors were tested monthly. Severity: 1 Scope: 3								
WW093 SS=F	NAC 449.441A.375 M suspected cases	lanagement of cases a	nd	WW093					

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/C		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
WE CARE	FOUNDATION		2216 S 6TH LAS VEGAS				
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WW093	the dependent and he residential care: Mana suspected cases; sur employees; counseling the considered to have to facility or a facility for managed in accordant Centers for Disease (adopted by reference subsection 1 of NAC 2. A medical facility, a home for individual maintain surveillance or home for tuberculo infection. The surveill conducted in accordant recommendations of the Control and Prevention transmission of tuberchealth care set forth in Centers for Disease (adopted by reference subsection 1 of NAC 3. Before initial emploin a medical facility, a a home for individual a: (a) Physical examinate licensed physician the good health, is free from any other communications of the preceding 12 months history of bacillus Cal vaccination.	dical facilities, facilities omes for individual agement of cases and veillance and testing of ag and preventive treatreculosis or suspected of the dependent must be accepted and Prevention in paragraph (h) of 441A.200. A facility for the dependent in paragraph (h) of employees of the facts and tuberculosis ance of employees must not with the culosis in facilities proving the culosis in facilities of the control and Prevention in paragraph (h) of 441A.200. Expendent, a person employees in the dependence of the dependence of the culosis in a person is in a state of the person is in a state of the person is in a state of the culosis in a contaguent to the person is in a state of the pers	ment. case I e of the as ent or cility st be diding as oyed ent or ave I a te of and gious	WW093			

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NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE			
WE CARE	FOUNDATION		2216 S 6TH S LAS VEGAS,					
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WW093	D PLAN OF CORRECTION IDENTIFICATION NUMBER: NVS3456HWH ME OF PROVIDER OR SUPPLIER Z216 S 6TH LAS VEGAS (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			WW093				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
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NAME OF DE	OVIDED OD CUIDDUED	NVS3456HWH	STDEET ADD	RESS, CITY, STA	ATE ZIP CODE	03/02	2/2011
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WE CARE	FOUNDATION			S, NV 89104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICIENCY)	CTION SHOULD BE COMI O THE APPROPRIATE DA	
WW093	Continued From page 9			WW093			
	of tuberculosis are present, the employee shall be evaluated for tuberculosis.						
	adopted by reference subsection 1 of NAC 4 3. Before initial emplo		oyed				
	in a medical facility, a facility for the dependent or a home for individual residential care shall have a:						
	(a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the		te of and				
		, including persons with	a				

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B. WING	03/02/2011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
WE CARE FOUNDATION 2216 S 6TH ST LAS VEGAS, NV 89104		
	(X5) COMPLETE DATE	
New No. 2 Continued From page 10 history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test of ther single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A 200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A 200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist,		

		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		' '	LE CONSTRUCTION	(X3) DATE S COMPL	
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	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2216 S 6TH ST LAS VEGAS, NV 89104				
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WW093	designated an infect any pulmonary sympo of tuberculosis are pevaluated for tuberc (Added to NAC by E 3-28-96; R084-06, 7 Based on interview the facility failed to ke for each member of	y if the medical facility hation control specialist, who toms develop. If symptoresent, the employee shulosis. Id. of Health, eff. 1-24-92 (-14-2006) In 3/2/11, it was determine a complete personne the staff of the facility (the employee files onsite).	nen oms nall be 2; A ined nel file	E60MM			